weighing being the DRG weight for the case.

$$\frac{\text{SUM}\,(\,s(i)\ x\ w(i)\,)}{\text{SUM}\,(\,w(i)\,)} = S$$

Where s(i) is the DRG severity of case i, w(i) is the DRG weight of case i, and the sum is taken over all non-Medicare cases i.

Let S(b) be the severity in the base year, and S(r) be the severity in the rate year. Then the percentage increase in severity is 100 x (S(r)/S(b) - 1).

2. Calculate the average aggregate severity of all the non-Medicare cases in the base year and in the rate year, T(b) and T(r) respectively. Calculate the average DRG weight for these cases, W(b) and W(r). The average severity in the base year is then T(b)/W(b)=S(b) and the average severity in the rate year is T(r)/W(r)=S(r). Then the percentage increase in severity is:

100 x (S(r)/S(b) - 1).

Method 2 is the more precise, therefore it is the one that should be offset against the case mix penalty.

94-03 MAR 15 1994

New JAN 1 1994

If this increase in severity is positive then it shall be used as an offset to the creep component of the case mix penalty to be applied for the year. If the creep component of the case mix penalty calculated by OHSM is P (as a percentage), and the percentage increase in severity is Q, then the case mix penalty shall be reduced to P - Q, but not to less than zero.

This reduction shall be applied to the case mix penalty for 1989 and for subsequent years of the FLHEP.

Future analyses are planned to determine how severity changes over time within individual hospitals, how stable the measures of severity are, whether the patients who are migrating to urban providers are doing so because they are more severely ill, and other studies that will enable the hospitals to obtain a better understanding of the needs of their patients. For example, a study may be performed to determine whether patients are being admitted to a hospital at an appropriate point in the course of their illness. Admission at too early a stage when treatment could equally well be performed on an ambulatory basis could indicate inappropriate resource use, while admission at too late a stage may result in higher resource use because the patients are more severely ill than they would be if they had been admitted at an earlier stage. The hospitals may also start to use the severity system to augment their utilization review function within the hospital.

Attachment A

The following are the major components of the trend factor methodology as adopted by the Panel of Health Economists.

Projection Methodologies

Salaries. In order to quantify the salary price movement component of the trend factor, four national salary proxies are used, adjusted by a Regional Adjustment Factor (RAF). The four salary proxies are the Collective Bargaining Agreements (Nonmanufacturing), Employment Cost Index - Private Industry Workers, Employment Cost Index - Managers and Administrators, and Employment Cost Index - Professional and Technical Workers. There four proxies are weighted to produce a composite salary price movement. (Separate weightings are used for teaching and non-teaching hospitals and the Health and Hospitals Corporation.) In calculating the initial trend factors for a given year, a projection methodology for salary price movements is used. The projections are based on the compounding of quarterly increases in the salary proxies for the four latest available quarters of data. The final trend factor calculations are based on actual proxy data for the trend factor year compared to the preceding year.

Fringe Benefits. The trend factor methodology uses a Total Compensation Factor (TCF) that measures the relationship between increases in total compensation (i.e., salaries and fringe benefits) and increases in salaries. This factor is then applied to the composite salary price movement to yield a total compensation price movement, hence reflecting the fringe benefits. Two national proxies are used to determine the total compensation factor: Employment Cost Index - Total Compensation - Private Industry Workers, divided by Employment Cost Index - Wages and Salaries - Private Industry Workers. In calculating the initial trend factors for a given year, the TCF is projected based on the latest four quarters data on these two proxies. For the final trend factor calculation, actual data are used

Labor. The labor portion of the trend factor refers to the combined salary and fringe benefits components. Hence, the labor price movement is the salary price movement, adjusted by the Total Compensation Factor (TCF) and by the Regional Adjustment Factor (RAF).

Non-labor. A number of different proxies are used to measure price movements in non-labor related expenses incurred by hospitals. In calculating the initial trend factors, an estimate of the non-labor component of the trend factor is made by using the projected Gross National Product Implicit Price Deflator as published by the American Statistical Association and National Bureau of Economic Research, Business Outlook Survey. The final trend factor calculations are made using the actual changes in the non-labor proxies.

Additional Disproportionate Share Payment -

The State's methodology used to take into account the situation of disproportionate share hospitals also includes additional payments to meet the needs of those facilities which serve a large number of Medicaid-eligible, low income and uninsured patients, including those eligible for Home Relief, who other providers view as financially undesirable. These payments are available to hospitals on behalf of certain low-income persons who are described below and are made in addition to, and not as a substitute for, disproportionate share payment described in sections 86-1.65, 86-1.74 and 86-1.84 of Part I. However, the calculation of hospitals bad debt and charity care experience used to determine the disproportionate share payments made under sections 86-1.65, 86-1.74 and 86-1.84 of Part I does not include costs of services to any person for whom an additional disproportionate share payment has been made under this provision.

These additional payment adjustments are made by the Department to disproportionate share hospitals who have provided services to persons determined to be low-income by reason of their having met the income and resource standards for the State's Home Relief program. These persons must have demonstrated to a local social services district or the Department that their household income and resources do not exceed the income and resources standard established by the Department, which standards vary by household size and take into account the household's regularly recurring monthly needs, shelter, fuel for heating, home energy needs, supplemental home energy needs and other relevant factors affecting household needs.

Each hospital will determine which patients qualify as low-income persons eligible for additional payments by a verifiable process subject to the above eligibility conditions. Each hospital must maintain documentation of the patient's eligibility for additional payments and must document the amounts claimed for additional payments. The supporting documentation must include written verification from a local social services district or the Department attesting to the person's eligibility for Home Relief. Such supporting documentation may be in the form of a photocopy of the person's current valid official benefits card or a copy of an eligibility verification confirmation received from the Department's Electronic Medicaid Eligibility Verification System (EMEVS), which system includes information with respect to persons eligible for Home Relief and additional payments, or other verifiable documentation acceptable to the Department which establishes that the person has met the income and resource standards for Home Relief on the date the services were provided.

OFFICIAL

A "disproportionate share hospital" for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low-income person without expectation of payment from the person due to the patient's inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above. In addition, a "disproportionate share hospital" (except hospitals serving an in-patient population predominantly comprised of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid-eligible patients on a non- emergency basis.

The amount of this disproportionate share adjustment will vary by hospital and reflect the dollar amount of payments from the State to the hospital for services provided to low income patients. For each hospital such adjustments shall be paid in the normal Medicaid payment process and according to established rates or fees. To receive payment of this adjustment each hospital must submit a claim in the form and manner specified by this Department.

HOSPITAL EXPERIMENTAL PAYMENT PROGRAM - (1988-1990)
TITLE XIX (MEDICAID) STATE PLAN AMENDMENT

88 9

This State Plan amendment is contingent upon an approved contract among the HEP participating hospitals, the Rochester Area Hospitals' Corporation (RAHC), and the contracting payors.

Effective January 1, 1988, Medicaid hospital inpatient reimbursement for all HEP-III participating hospitals will be through a DRG-based case payment methodology similar to the case payment methodology for the rest of the State. However, the Medicaid case payment rates for the HEP-III participating hospitals will be based on their 1987 HEP-E payment bases (which were the original 1978 HEP cost bases trended forward and adjusted). The 1987 total payment base for each hospital is allocated to non-Medicare patients using 1987 utilization data and then trended to 1988 by an inflation factor. The non-Medicare inpatient acute portion of each hospital's 1988 payment base is then converted to an inpatient Medicaid case payment rate for each DRG. There is a blending of the hospital specific case payment rate and a group pricing component, in proportions identical to those followed by hospitals in the rest of the State. Medicaid Alternate Level of Care (ALC) patients will be reimbursed at the regional nursing home per diem rate, according to the same methodology as under the State's overall system.

Whereas, in most respects, the Medicaid inpatient reimbursement methodology in the proposed HEP-III system is the same as that for the rest of the hospitals in the State, there are unique features of the system. The chief of these is the development (in 1988) and implementation (in 1989 and 1990) of a completely new system to provide financial incentives for quality patient care which may be able to be used in the future on a wider scale if its feasibility is demonstrated among the HEP-III hospitals. The quality assurance system will use the MEDISGRPS severity classification system and develop standards against which each hospital's inpatient care will be assessed. The hospital will face financial incentives (within limitations) to assure that these standards are met.

The HEP-III hospitals will also continue to pool capital costs, medical education and physician coverage costs (through the concept of levelling).

Methods and Standards for Establishing Payment Rates

Out-of-State Services

I. Inpatient Hospital Care

New York reimburse's out-of-state hospitals at the facility's Medicaid rate established by the State in which the institution is located; or when no such rate exists, at the lowest of the following charges:

1. the Medicare rate set for the hospital; or
2. the hospital's customary charge for public beneficiaries; or
3. the maximum New York State Title XIX rate for similar inpatient care.

Reimbursement for those days where recipients are awaiting placement to an alternate level of care (ALC) while they are inpatients at out-of-state hospitals will be at the facility's approved Medicaid ALC rate.

II. Additional Disproportionate Share Payment

The State's methodology used to take into account the situation of disproportionate share hospitals also includes additional payments to meet the needs of those facilities which serve a large number of Medicaid-eligible, low income and uninsured patients, including those eligible for Home Relief, who other providers view as financially undesirable. These payments are available to hospitals on behalf of certain low-income persons who are described below.

These additional payment adjustments are made by the Department to disproportionate share hospitals who have provided services to persons determined to be low-income by reason of their having met the income and resource standards for the State's Home Relief program. These persons must have demonstrated to a local social services district or the Department that their household income and resources do not exceed the income and resources standard established by the Department, which standards vary by household size and take into account the household's regularly recurring monthly needs, shelter, fuel for heating, home energy needs, supplemental home energy needs and other relevant factors affecting household needs.

Each hospital will determine which patients qualify as low-income persons eligible for additional payments by a verifiable process subject to the above eligibility conditions. Each hospital must maintain documentation of the patient's eligibility for additional payments and must document the amounts claimed for additional payments. The supporting documentation must include written verification from a local social services district or the Department attesting to the person's eligibility for Home Relief. Such supporting documentation may be in the form of a photocopy of the person's current valid official benefits card or a copy of an eligibility verification confirmation received from the Department's Electronic Medicaid Eligibility Verification System (EMEVS), which system includes information with respect to persons eligible for Home Relief and additional payments, or other verifiable documentation acceptable to the Department which establishes that the person has met the income and resource standards for Home Relief on the date the services were provided.

OFFICIAL

A "disproportionate share hospital" for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low-income person without expectation of payment from the person due to the patient's inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above. In addition, a "disproportionate share hospital" (except hospitals serving an in-patient population predominantly comprised of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid-eligible patients on a non- emergency basis.

The amount of this disproportionate share adjustment will vary by hospital and reflect the dollar amount of payments from the State to the hospital for services provided to low income patients. For each hospital such adjustments shall be paid in the normal Medicaid payment process and according to established rates or fees. To receive payment of this adjustment each hospital must submit a claim in the form and manner specified by this Department.

OFFICIAL

Rate Setting and Financial Reporting

(a) For the purpose of this section, the following definitions shall apply:

(1) Specialty Hospital or "Facility" shall mean that program and site for which OMRDD has issued an operating certificate, pursuant to Mental Hygiene Law Article 16, to operate as a Specialty Hospital, and for which the New York State Department of Social Services has issued a Medicaid provider agreement[.] and which is subject to the special rule described in section 1923(e) of the Social Security Act.

(2) "Provider" shall mean the individual, corporation, partnership or other organization to which the OMRDD has issued an operating certificate, pursuant to Mental Hygiene Law Article 16, to operate a Specialty Hospital, and to which the New York State Department of Social Services has issued a Medicaid provider agreement for such facility.

(3) "Alternate Care Determined Client" or "ACD Client" shall mean a client who has been determined not to require specialty hospital care after completion of an independent utilization review, pursuant to 14 NYCRR Section 680.9.

(4) A "newly certified facility" shall mean a facility which has been in operation less than two years and has not yet submitted a cost report which covers a full 12 months of operation for any rate period January 1 to December 31 or any other 12-month period designated by the commissioner according to Section (b)(1)(ii)(b).

(5) "Actual cost" shall mean the costs that were audited and stepped-down by OMRDD or its agent for the specialty hospital and which are taken from the financial reports filed annually in accordance with Section (b)(1)(ii) and which cover a full 12-month period of operation beginning 24 months prior to the effective date of the rate period in question. For the rate period from June 10, 1988 to December 31, 1988, as stated in Section (d)(3), the actual costs defined in the preceding sentence shall be taken from the annual financial information filed by the provider for the calendar year 1985 with Blue Cross/Blue Shield of Greater New York.

TN 88-14 Approval Date MAR 08 1991

Supersedes TN NEW Effective Date JUN 10 1988

(6) "Budget costs" shall mean the financial information submitted by a provider in accordance with Section (b)(1)(i).

(7) "Reimbursable costs" shall mean those actual or budget costs which are determined, based on a line item review/desk audit process by OMRDD or Blue Cross/Blue Shield of Greater New York, to be allowed in accordance with Section (d)(8).

(8) "Operating cost" shall mean a facility's costs, other than capital costs or start-up costs, which include Personal Service costs, Administrative and General Services costs, and Other Than Personal Service (OTPS) costs.

(i) Personal Service costs include costs such as salaries, fringe benefits, and accrued vacation costs for employees of the specialty hospital; and costs of persons performing services under contract to the specialty hospital. Services refers to the provisions of routine and ancillary care of clients admitted to the specialty hospital in accordance with the provisions contained herein.

(ii) Administrative and General Service costs refer to departments, divisions or other units which are operated for the benefit of the specialty hospital as a whole, and includes activities such as management, housekeeping, laundry, dietary services, and operation and maintenance of grounds and physical plant.

(iii) OTPS costs include, but are not limited to, the costs of items such as food, minor equipment, supplies and materials, travel, medications and utilities.

(9) Capital costs shall mean property costs subject to the limitations contained herein and allowance for depreciation and interest on capital assets according to Medicare principles or reimbursement.

(b) Reporting Requirements

(1) Financial reports shall include the following:

(i) Budget Reports

(a) Each provider intending to operate a specialty hospital shall include budget reports in its application to receive an operating certificate.

TN 88-14 Approval Date MAR 08 1991
Supersedes TN NEW Effective Date JUN 10 1988